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BMJ Open *'I did try and point out about his dignity': a qualitative narrative study of patients and carers' experiences and expectations of junior doctors*

Camille E Kostov,¹ Charlotte E Rees,² Gerard J Gormley,³ Lynn V Monrouxe⁴

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¹Salisbury District Hospital, Salisbury, UK

²Faculty of Medicine, Nursing and Health Sciences, Monash Centre for Scholarship in Health Education (MCSHE), Monash University, Melbourne, Victoria, Australia

³Centre for Medical Education, Queen's University Belfast, Belfast, UK

⁴Chang Gung Medical Education Research Centre (CG-MERC), Chang Gung Memorial Hospital, Linkou, Taoyuan, Taiwan

Correspondence to

Professor Lynn V Monrouxe;
monrouxe@me.com

ABSTRACT

Objectives For many years, the voice of patients has been understood as a critical element for the improvement of care quality in healthcare settings. How well medical graduates are prepared for clinical practice is an important question, but one that has rarely been considered from patient and public perspectives. We aimed to fill this gap by exploring patients and carers' experiences and expectations of junior doctors.

Design This comprises part of a wider study on UK medical graduates' preparedness for practice. A qualitative narrative methodology was used, comprising four individual and six group interviews.

Participants 25 patients and carers from three UK countries.

Analysis Data were transcribed, anonymised and analysed using framework analysis.

Main results We identified three themes pertinent to answering our research question: (1) sources of knowledge (sources of information contributing to patients and carers' perceptions of junior doctors' impacting on expectations); (2) desires for student/trainee learning (experiences and expectations of medical training); and (3) future doctors (experiences and expectations of junior doctors). We also highlight metaphorical talk and humour, where relevant, in the quotes presented to give deeper insights into participants' perspectives of the issues. Participants focused on personal and interpersonal aspects of being a doctor, such as respect and communication. There was a strong assertion that medical graduates needed to gain direct experience with a diverse range of patients to encourage individualised care. Participants narrated their experiences of having symptoms ignored and attributed to an existing diagnosis ('diagnostic overshadowing') and problems relating to confidentiality.

Conclusions Our findings support the view that patients and carers have clear expectations about junior doctors, and that patient views are important for preparing junior doctors for practice. There is a necessity for greater dialogue between patients, doctors and educators to clarify expectations and confidentiality issues around patient care.

INTRODUCTION

Medical education aims to prepare graduates to work as safe, compassionate and competent

Strengths and limitations of this study

- With a plethora of research on medical students and doctors' opinions, our study uniquely gives voice to patients and carers about their views of medical training in the UK.
- This is a multisite study with patients representing three UK countries.
- Participants focused on issues of respect, communication and the need for doctors to be trained for a diverse patient cohort.
- Participants were mainly part of support groups and charities and thus might be more politicised than the general public.
- The majority of participants were female and/or mature so the views of male and younger patient groups are not as well represented.

doctors.^{1–3} Globally, medical education is changing in response to an ageing population, increasing numbers of people living with chronic multiple comorbidities, greater emphasis on cost-effectiveness and rising public and patient expectations.^{4–8} The term 'junior doctor' is often used to describe doctors across a variety of levels, but here we refer to those in their first 2 years of work following graduation. Concerns have been raised that medical graduates are not fully prepared to begin their roles as junior doctors, falling short of wider public expectations. For example, issues have been raised regarding patient safety and effectiveness of care when medical graduates begin work, which is exacerbated by other doctors rotating to new posts simultaneously. This is known as 'the August changeover', 'black Wednesday' and the 'July phenomenon' in the UK and USA, respectively.^{9 10} Such fears are communicated to the public via the media, with reports of increased death rates and pleas for junior doctors to work within their limits.^{11–13}

Similarly, there have been concerns relating to the lack of support for junior

doctors, especially while working on call.^{14 15} Healthcare-related television programmes are popular with the general public, and it has been suggested that this may be contributing to the rise in complaints from patients about doctors.^{16–18} The role of junior doctors in recent National Health Service (NHS) scandals has also been highlighted.¹⁹ More recently, junior doctors in the UK have received both positive and negative press through discussions regarding the imposition of new contracts, and subsequent industrial action (ie, strikes) taken by them.^{20–22} Such media coverage and governmental reports influence public perceptions of the healthcare system, including the important roles of junior doctors.

As a response to fears that medical graduates might be unprepared, a range of stakeholders' views have been sought on the topic of graduates' preparedness for work, including that of junior doctors, supervisors, educators, other healthcare professionals, employees and policy-makers.^{1 23–27} In the largest UK study to date on the topic, with over 11 000 participants, a third of junior doctors disagreed that their medical school had prepared them well for practice.²⁸ In a more recent national training survey, 70% of junior doctors reported being 'adequately prepared' for their first foundation programme posts.²⁹ Specific clinical tasks have been identified for which junior doctors overall report being well prepared (eg, history taking and clinical examination) or underprepared (eg, prescribing of medicine and emergency care).^{30–34} Similar findings on preparedness are mirrored internationally,^{3 35} as well as additional aspects such as holistic and empathic patient care.^{36–38}

For many years now, since the physician–patient relationship has become more of a partnership, patients have been valued in terms of their potential contribution to the development of tomorrow's doctors, including: medical student selection, direct teaching and assessment, curriculum development and quality assurance.^{39 40} Furthermore, patients' experiences have been conveyed to doctors and students both face-to-face and via valuable learning resources (eg, <http://www.healthtalk.org> and <http://www.youthtalk.org.uk>). But despite the recognition that patients should be involved in medical education and research,^{2 41} they are rarely consulted on matters such as medical graduates' preparedness for practice. Indeed, a recent rapid review of the literature from 2009 to 2014 on UK graduates' preparedness for practice only identified 1 (of 87) manuscript with patients as participants.⁴² The study identified is in the setting of patient safety teaching across multiple healthcare education curricula, and the results from the patient group are largely amalgamated with the other stakeholders' data.⁴³ Thus, while a range of stakeholders have been consulted previously, patients are rarely asked, with the majority of research comprising self-reported data on preparedness confidence. This paper therefore aims to address critical current gaps in the literature by giving voice to patients and carers regarding their views of medical training. In doing so, we propose to answer the research question: What are patients and

carers' experiences and expectations of junior doctors? Note that experiences are occasions lived by our participants, whereas expectations are their opinions that something might occur or a presumption that someone might behave in a particular way. These two aspects can be related, for example, current experiences of junior doctors might influence future expectations of junior doctors and likewise, current expectations about junior doctors might affect future experiences of junior doctors. However, there might also be a gap between expectations and experiences, for example, a patient might expect a junior doctor to lack communicative competence but then be pleasantly surprised by the interpersonal skills of a junior doctor they experience (thus their experience exceeds their expectation). Therefore, we draw both on patient representatives' experiences and expectations in the current paper.

METHOD

Design

We followed a qualitative narrative interview design to explore patients, their representatives and carers' experiences of junior doctors across three UK countries: Wales, England and Scotland. We used purposive sampling to identify appropriate participants. Data were collected as part of a wider UK study on graduates' preparedness for practice commissioned to inform the development of the General Medical Council's (GMC) outcomes for graduates document.⁴⁴ This included narrative interviews with a variety of stakeholder groups: junior doctors, clinical supervisors, other healthcare practitioners, undergraduate and postgraduate deans, patients and carers, government officials and policymakers, along with a longitudinal audio-diary (LAD) study with junior doctors (total number of LAD entries=185²⁶). A narrative approach allowed us to explore participants' perceptions of preparedness, and focusing on their own lived experiences rather than general attitudes and beliefs.⁴⁵

Narrative theory proposes that people share 'stories' as a way of making sense of events that occur and of the world around them, within a specific social and cultural context and as such are co-constructed within that cultural context.⁴⁶ Narratives come in a range of forms. Although not all aspects are present, and the order is often recursive, narratives comprise stories of events that have occurred in the narrator's past, often with an opening *abstract* (summarising the event in a few words), followed by an *orientation* (who was present, where the event occurred), then the *sequence of events* (the turning point, the 'problem', from the narrators' perspective), then the *resolution* and an *evaluation* of the event.⁴⁷ Narratives can also come in the form of 'small stories'—in the form of *narrative-as-talk-in-interaction*.^{48 49} These can be seen as comprising *narrative activities* that include stories of ongoing, future or hypothetical events (so, not restricted to past events), shared (and therefore *known*) events, along with allusions to (previous) stories



of events and deferrals/refusals to tell the story. These have been referred to as *fleeting moments* comprising a narrative orientation to the world,⁵⁰ occurring within conversations between people who have a shared history (including a shared culture). Analysis of narrative data allows insights to be gained into individuals' experiences of events,⁵¹ alongside their orientations to specific aspects of the world. Narrative theory and analysis can therefore enable us to explore patients and carers' experiences and expectations of junior doctors, and the ways in which their views are formed.

We arranged focus groups wherever possible to enable comparisons to be made between different participants' points of view and to understand how meanings are constructed within the group.⁵² While we preferred to conduct focus groups wherever possible because of the benefits of group interviews (eg, stimulation, snowballing, safety, and so on). We also offered individual interviews to those who preferred that method and for those participants who volunteered alone (ie, no one else from their location volunteered to participate). Crystallisation of data by combining focus groups and interviews allowed greater depth of inquiry and thus a more comprehensive and deeper understanding of participants' views.⁵³

We developed an interview guide from questions set for the wider study and also based on the feedback from an initial pilot interview with a patient involvement representative (see Acknowledgements section). Although we encouraged participants to recall first-hand experiences with junior doctors, participants also recalled stories of preparedness that were not directly experienced by the narrator, or experiences with the wider healthcare system. In addition to narratives of events, participants also revealed their attitudes towards and expectations of junior doctors' preparedness through evaluative comments (not specifically linked to any single event). Although we report our analysis of data from patient representatives separately from other stakeholder groups due to the different (although slightly overlapping) set of analytical themes, we compare our patient-related findings with those of other stakeholders later in our discussion.²⁶

Recruitment

A purposive sampling approach was used. Following university, medical school and/or health board ethical approval across all sites involved in the wider study, we approached patient representatives from a variety of different backgrounds.⁵⁴ We took particular care to involve patient representatives who reflected the changing demographics of our ageing population and increased numbers living with chronic disease. There were no specific selection criteria, as we wanted all members who felt they could speak on behalf of patients about their experiences and expectations of junior doctors to come forward. Only patients with stable conditions (and their carers) were recruited to this study, for two ethics-related reasons. First, we thought that patients with stable conditions would be

Table 1 Participant demographics

Characteristic	Frequency
Age range (years)	
25–45	1
46–65	8
66–85	14
No information	2
Gender	
Female	17
Male	8
Self-identified nationality	
British	12
English	2
Scottish	2
Welsh	8
No information	1

less vulnerable than those currently experiencing acute-phase illness and would therefore find the interview participation less challenging and arduous. Second, our university-based ethics approval was sufficient to enable us to recruit patients (and carers) via non-clinical sites but was not sufficient for patients with active illnesses to be recruited directly from hospitals where junior doctors worked. Thus, we approached patient support groups and charities, encouraging participants to come forward to contribute to the study as part of a group. We also recruited a number of patients who were involved in medical students' learning, during which time they acted as simulated patients (ie, as actors for students to practice communication and clinical skills).⁵⁵

Participants

We conducted 10 (4 individual and 6 group) interviews with patient representatives (n=25) across three of the four UK country sites, comprising 9 hours and 58 min of data (see [table 1](#) for demographic details). The main medical conditions represented by participants were dementia, chronic respiratory diseases and learning disabilities. All participants, including the simulated patients (n=2), spoke to us from the perspective of their roles as patients and carers. Of those who identified themselves as carers (n=9), a number also spoke of their own experiences as patients. Some participants had backgrounds in the healthcare professions, though all were retired (including four nurses, a paramedic, a social worker, an occupational psychologist and an occupational health advisor).

Data collection

The researchers came together for a 2-day orientation and team-building exercise during which time they practised their narrative interviewing skills under the direction of LVM. Three researchers (CK, NK and GS; KK supported CK during initial interviews, see

Acknowledgements section) then conducted the interviews in their own country location using the same interview guide, following a semistructured narrative approach. Most of the interviews took place at the support groups' usual meeting places or offices, hoping that the familiar environment would encourage participants to share their experiences.⁵⁶ Groups were kept relatively small (n=2–6) for practical reasons, and also for intimacy. At the start of the interview, we introduced the project and confirmed all participants understood how medical graduates are currently trained, ensuring they were familiar with the term 'junior doctor'. Interviews explored participants' understandings of the concept of 'preparedness for practice' and their personal experiences relating to this concept (eg, when starting a new job themselves). Participants were invited to share their experiences of junior doctors, and were prompted to expand on how prepared junior doctors were in each instance. Finally, we asked participants to comment on how prepared for practice they felt that junior doctors were overall.²⁶ All interviews were audio-recorded, transcribed verbatim and anonymised using pseudonyms for all participants except one carer, who explicitly asked that she and her husband be named (see Acknowledgements section).

Data analysis

Using Ritchie and Spencer's⁵⁷ five-step framework analysis (involving data familiarisation, thematic framework identification, indexing, charting, mapping and interpretation), 10 researchers from four UK countries involved in the wider study met over 2 days. Following familiarisation with the data from all stakeholders, a thematic framework for the wider study was developed both deductively (using outcomes for graduates from *Tomorrow's Doctors*: GMC 2009/2015 and inductively from the data).⁴⁴ As data from patient representatives were less clinically focused than other groups and contained fewer preparedness/unpreparedness judgements, further development of the thematic analysis for these data was undertaken by LVM, KK and CK to capture the range of themes. CK indexed and charted the data using ATLAS.ti with cross-checking by the wider team. We established credibility and confirmability by describing our analytical methods, involving multiple data analysts and using illustrative quotes. Transferability was established through our inclusion of a diverse group of patients and carers from three UK countries.⁵⁸

RESULTS

Through thematic framework analysis of the data from patient representatives we identified nine themes in total, of which there were seven content-related themes (ie, *what* people said) and two process-related themes (ie, *how* they said it): in this paper we concentrate on the three themes (summarised in [box](#)) that were most pertinent to answering our research question: (1) sources of knowledge (sources of information that contribute to patients and

Box Outline of the three study themes

1. *Sources of knowledge*: This theme aims to identify and contextualise patient representatives' experiences and personal views on junior doctors' preparedness for work. It includes:
 - 1.1. *Patient representatives' first-hand experiences* with junior doctors and the healthcare system in general ('it happened to me').
 - 1.2. *Patient representatives' secondhand experiences* ('it happened to them').
 - 1.3. *Their views as influenced by media and popular culture.*
2. *Desires for student/trainee learning*: This theme collects patient representatives' perceptions and expectations for junior doctors in terms of medical training. It includes:
 - 2.1 *Patient diversity*: Patients from different socioeconomic and cultural settings will help junior doctors in their preparedness for practice. Junior doctors should also work with vulnerable patients (eg, patients with learning disabilities; mental health issues) to practice interpersonal skills (ie, respect, understanding, empathy).
 - 2.2 *Broad training base*: Junior doctors should broaden their knowledge and perspectives on more than one medical specialty.
 - 2.3 *Lifelong learning and development*: They should constantly strive to develop both professionally and personally.
 - 2.4 *In-depth clinical reasoning*: They should shun 'diagnostic overshadowing' (ie, avoiding or only reluctantly drawing conclusions on a disease and its symptoms that move away from the original diagnosis).
 - 2.5 *The need for support*: Junior doctors should be provided with both clinical and pastoral support (including support from peers and seniors).
3. *Future doctors*: This topic deals with patient representatives' expectations and experiences for junior doctors as human beings. The theme comprises:
 - 3.1 *Patient-centred communication*: Desired communication skills in junior doctors include empathy, dignity and willingness to work with patients as partners.
 - 3.2 *Greater respect*: Junior doctors (and also seniors, nurses and nursing staff) should develop respectful attitudes towards patients. Lack of respect is a source of stress and emotional burnout for both care providers and recipients.

carers' perceptions of junior doctors' impacting on their expectations; (2) desires for student/trainee learning (experiences and expectations of medical training); and (3) future doctors (experiences and expectations of junior doctors). We also draw the reader's attention to metaphorical talk and humour where relevant in the quotes presented. The themes discussed in this paper go beyond the main themes discussed earlier by Monrouxe and colleagues,²⁶ which concentrated mainly on junior doctors' preparedness in relation to the outcomes listed for graduates.⁴⁴

Few differences were identified in the data regarding different patient groups. Carers were more likely to talk about certain difficulties, for example, communication barriers related to confidentiality and the issue of diagnostic overshadowing (ie, dismissing underlying 'other' symptoms as part of an existing diagnosis). Although some of our patients and carers had previously worked within the health system (as mentioned above), it was not



possible to ascertain whether or not this produced differences in the data given our qualitative approach.

We present our themes and subthemes below with representative excerpts from the data. These excerpts are reproduced within their interactional context where appropriate (rather than cleaned up to look like solo narratives) to enable the reader to see how they were co-constructed (as *narrative activities*) within the social interaction of the group and individual interviews. Remarks on how to interpret the transcription notations in the quotes that follow include: **bold** used to emphasise appropriate content for the theme (added by authors); underline for accentuated speech; ‘—’ for sudden break in speech; [] for additional information to add contextual clarity; () for anonymised information, for example, (name of hospital); and (()) for additional information regarding non-verbal language, for example, ((laughter)).

Theme 1: sources of knowledge

This theme is concerned with how the various sources of information contributing to patients and carers’ perceptions of junior doctors’ preparedness for practice appeared to impact on their expectations of them. The data coded to this theme include: (1) patients’ first-hand narratives of personal experiences with junior doctors and the wider healthcare system; (2) their ‘second-hand’ narratives of experiences from friends and family members; and (3) patients’ personal views of junior doctors as influenced by popular culture and the media (often narrated as impersonal ‘they’).

First-hand narratives

‘*It happened to me...*’: Although patients’ first-hand narratives included communication problems such as being spoken *about* rather than *with* (as a patient) and lack of support and involvement (as a carer), participants also narrated positive experiences regarding the care they received by junior doctors, and this was sometimes framed in contrast to the behaviour displayed by seniors:

On one occasion we had to go to A&E when my husband was quite ill. He has heart failure but he has other problems as well. Now, as we went in the doctor [consultant] said straight away, ‘*Now do you want to be resuscitated?*’ The other thing, I think he’d had a really bad day this doctor; he turned around and said to my husband, ‘*You know you’re taking up a bed, and somebody might be really ill and they might need it more than you?*’ And this is actual fact. It’s actually what he said. **And yet, one of the junior doctors came up to us and she said,** ‘Don’t worry about that, we’re not sending him home.’ (Shirley, Focus Group 6)¹

Interestingly, participants’ first-hand narratives were generally more positive than secondhand narratives recounted of others’ experiences and media-influenced personal views. Indeed, when drawing on these latter two

sources of knowledge the narratives were predominately negative, as will be illustrated next.

Secondhand narratives

‘*It happened to them...*’: Participants’ narratives tended to be more negative when sourced from secondhand knowledge (ie, the experiences of friends, family members or colleagues) and focused on problematic role models from which junior doctors were learning:

John: **I was speaking to somebody else** about the culture in organizations. Within hospitals you have subcultures, and some wards can be very good, and it depends on whose running them, you know, do they listen to patients or whatever.

Liz: Yeah, yeah. In a certain hospital, there are two wards. You go into the one ward and everything is fine. You go into the other ward and it’s terrible. But it does go down to who is in charge and what special-ists are on that ward. **But if that’s your first ward as a junior doctor that is what you’ll learn. And if it’s the bad ward, you’re learning the bad practice.**

John: Yes, definitely.

Liz: It’s terrible really.

(John and Liz, Focus Group 2, Site 1)

Knowledge from the media

‘*Did you see the news?*’: Participants also tended to be more negative when influenced by the popular press, constructing future hypothetical conversational narratives as they oriented to the world through sensationalised media reports. For example, participants in one focus group joked about the dangers of going into hospital in August during graduates’ first days of work, evidently based on information sourced from the media:

Liz: **They** [the media] **do say**, ‘Don’t go into hospital in August because you’ll die.’

John: That’s right, don’t.

Liz: No, they do say that ((*General laughter*)).

Stephanie: Or at the weekends.

Liz: You know, it’s quite frightening. Don’t get ill. **Feed yourself in the house like, you know, but don’t go into hospital.**

(Liz, John and Stephanie from Focus Group 2, Site 1)

In contrast, participants constructed positive images of junior doctors when they talked about watching television programmes, leading to them developing a compassionate, understanding and sympathetic notion of junior doctors in comparison to those from previous generations:

Holly: I think the students—doctors today—I **think they’ve got a bit more—understanding than the older doctors**, you know, they do ask. With older doctors, I suppose it’s the way they were trained, I don’t know, but the students I think have more care—

William: Sympathetic.

Holly: —**I've been watching them doctors on the telly.**

Tom: Compassion.

Megan: Eager to please.

(Holly, William, Tom and Megan from Focus Group 5, Site 1)

To summarise this theme 'sources of knowledge', patients and carers drew on first-hand and secondhand experiences, plus their knowledge of the media when articulating their perceptions of and expectations for junior doctors' preparedness. While they experienced communication problems and a lack of involvement first-hand, they perceived junior doctors' communication to be superior to those of senior doctors, with their first-hand narratives being more positive than secondhand ones. Indeed, secondhand narratives typically problematised junior doctors' senior role models, while media representations gave patients and carers' mixed views of junior doctors' preparedness, ranging from print media fear—mongering about general junior doctor incompetence to more positive personalised and human representations of junior doctors in TV documentaries. Such patient and carer perceptions are based on these sources of knowledge and intertwined with their perceptions about student/trainee learning, which we discuss next.

Theme 2: desires for student/trainee learning and support

This theme concerns patient representatives' perceptions of the aspects of student/trainee learning that they highlight as being important. These comprise: (1) experiences across patient diversity (including various diseases, ages, socioeconomic and cultural backgrounds); (2) experiences across a broad range of clinical specialties; (3) lifelong development of knowledge and skills; (4) in-depth clinical reasoning (ie, not limiting conclusions to a single diagnosis, and not letting an existing diagnosis overshadow new comorbidities); and (5) the need for academic, clinical and pastoral support.

Patient diversity

Patients and carers expected junior doctors to be trained across a diverse range of patients, preparing them to be responsive to the needs of the population. Patient representatives narrated that trainees should gain direct experience caring for patients from various socioeconomic and cultural backgrounds, learning to consider how such backgrounds affect disease presentation and patients' abilities to cope. Seeing patients in their own environments, whether at home or in community settings, was suggested as a way to expose students such diversity. One participant illustrates this in his narrative by using metaphorical talk, which along with his use of '*they*' for junior doctors reveals how he sees the doctor–patient relationship as somewhat adversarial:

... you know, GPs practice for a few months to see the type of patients that will eventually end up in

hospital, because... I think a lot of the junior doctors come from middle class backgrounds therefore they might... not know what life is like **on the other side of the fence**, you see in the poorer quarters, the estates or the ghettos as they call them in America... and there are plenty in this country and in [city]... if they went in a GP practice in certain areas and saw the people and how they live perhaps they'd have a better idea... (Tom, Focus Group 5, Site 1)

Additionally, participants narrated that junior doctors needed to learn how to care for vulnerable groups, such as those with learning disabilities or mental health problems, understanding their specific health and social care needs. Beyond this, participants explained that doctors' individual attributes affected their abilities to care for diverse patients, suggesting that some of these skills could not be taught. One carer illustrated this point when narrating a series of events around his mother's carers in a nursing home. He talked about how qualities such as understanding and empathy are innate, although he also employed a powerful metaphor of education as a journey ('*going down a road*'), to illustrate that some of these things could be developed:

We're [patients and doctors] not all equal. So the people [doctors] who are successful with patients at risk or more demanding patients, that's a special kind of person and although it's possible to train individual doctors to become more understanding, unless they've really got it within them, I think they're only going to **go so far down that road** of having full understanding, full empathy, full willingness to spend time—I've seen some care staff dealing with my mother who was very aged and in a care home. Some care staff were exceptionally good, and other staff were okay. And I put that down not to their training, not to their age, not to their experience, but to themselves. They just have a better understanding, a better willingness, a better desire to undertake that kind of work. And some doctors will fit that bill but not all. (Jack, Interview 1, Site 2)

Broad training base

As well as diversity in patient background, participants also narrated that students must be taught broadly about all conditions and medical specialties, regardless of their future career plans. For example, Harry narrated the hypothetical thoughts⁵⁹ of a medical student that he considered appropriate for approaching their learning:

Harry: Well I think **any student going into medicine at the moment has got to look at the broader spectrum**, and once they've got an idea of everything that's going on, then they can decide in their mind, '*This is the way I want to go, or that's the way I want to go.*'

Nick: Yeah.



Harry: It's the benefit obviously of going into the general practices and following your consultants around and everything else. It's the correct and right way to do it.

(Harry and Nick, Focus Group 5, Site 1)

Lifelong development

Participants also highlighted that all doctors should continue to develop their knowledge and skills throughout their careers, in terms of technical clinical knowledge, and by growing as a person. However, their own experiences of this were not always positive as the following narrative suggests:

Jessie: When we are delivering the 15–20 min presentation to them, **they're not—sort of they are taking it on board**—but then we've got to go back again, but this time—cause they get passed—we've got to do it to the medical students again—and to the nurses and doctors which are on the ward, 'cause we deliver um—this for the awareness training...to hospital staff, but at the moment—**some of them are taking it on board but the hierarchy people—the very hierarchy people—the professional people are not...the doctors who are very high up...**' cause they're not taking no hand outs no nothing at all...

Danna: they didn't really take it that good did they?

Jessie: **they didn't take it that good at all...**that's the worst side we saw—so far.

(Jessie and Danna, Focus Group 3, Site 2)

In-depth clinical reasoning

A number of patient representatives described the issue of what one participant referred to directly as: '*diagnostic overshadowing*' (Elaine, Focus Group 3, Site 1). Diagnostic overshadowing occurs when once a main diagnosis is made, all other symptoms and issues are associated with that diagnosis, thereby overlooking coexisting conditions. Another participant expressed the need for junior doctors to learn how to listen to carers as a way of preventing such diagnostic overshadowing as she narrated an event involving her husband and the physical pain he was experiencing. In doing so, she revealed two different, but both oppositional, ways in which she understood the doctor–patient relationship: as a game ('*playing the system*') and as war ('*fighting your corner*')

I think too often people are dismissed with one diagnosis, when in fact they've got an underlying urinary tract infection, or chest infection, or a pain, which they can't express anyway. But we know, as their loved ones and their next of kin living with them 24/7, that he is in pain somewhere. And I think that's probably one of the biggest frustrations that I found. And because I know how to **play the system**, we got a lot quicker response than many of the thousands of carers out there that don't know how to do it. And that makes me angry, but you're going to **fight your**

corner first and foremost. It's just those sorts of things that make caring so impossible, or so very challenging—so very difficult, and why people collapse under the strain. (Rosie, Focus Group 6, Site 1)

Additionally, carers narrated events suggesting that once a simple diagnosis has been reached, doctors can be reluctant to look for additional complexities:

Yeah, you know when you said about the junior doctor—I'm talking about in the hospital setting when my children finally got to (name of hospital) and we all had to say what—and the junior doctor was taking notes, and so on... and I just feel that they've got somewhere there's an algorithm which they say, 'Yeah, yeah, yeah, yeah, diagnosis. Full-stop. Don't want to know anymore.' (Kate, Focus Group 6, Site 1)

The need for support

Finally, participants narrated events that made them conclude that junior doctors needed support: both clinical support on busy wards, as well as pastoral support. It was identified that support from peers and from seniors may both be important in different ways. For example, Liz narrated her in-depth knowledge of junior doctors' experiences when she told the group about how little she had experienced junior doctors being supported during ward rounds. Interestingly, she demonstrated her empathy with the junior doctors and narrated a future hypothetical event, based on past experiences, by placing herself in the role of the junior doctor (note, Stephanie uses the term 'the firm', which no longer exists now, instead of 'the team'):

Stephanie: I think junior doctors need support beyond the firm they're working with.

Liz: Because it must get frustrating. I mean if you go around the ward and you count to twenty and they're [patients] all awkward.

Stephanie: ((laughter)).

Liz: At the end of the ward you think, '*Ah I'm going to kill them all.*'

Stephanie: But you can't say that to your consultant. **Whereas if you had a little group where you could go to where it was acceptable to say that** and have a laugh about it that would make a lot of difference. **But also you need superiority in there to give you permission**, to feel that, you know.

(Stephanie and Liz, Focus Group 2, Site 1)

To summarise this theme 'desires for student/trainee learning and support', patients and carers talked about their expectations for student learning so that graduates were properly prepared for practice. Participants had expectations that students were educated to work with diverse patients and vulnerable groups, that they were taught about a diverse range of conditions and specialties, that they were committed to lifelong learning, that they

had good clinical reasoning and were open to involving patients and carers in clinical reasoning, and finally, that they were well supported. Such participant desires for students learning and support were related to the key capabilities they wanted from future doctors, which we turn to next.

Theme 3: future doctors

This theme concerns the key skills and qualities that patient representatives desired from future doctors, and included: (1) patient-centred communication and (2) greater respect (ie, listening to patients and carers, treating them as individuals and addressing their needs and concerns).

Patient-centred communication

Participants narrated situations in which they felt disempowered and vulnerable when entering hospital. Ultimately, they felt that junior doctors should be well prepared to communicate effectively with patients on all levels: rapport building with patients who are often nervous in the clinical setting, treating them with respect, dignity and working in partnership with them. For example, Gavin shared his story about how he felt when he arrived at hospital leading him to assert that all doctors should understand and react to patients' vulnerabilities:

... you come into a strange building, you're sort of in a state of shock, you don't know the building, the professionals do, and there's this, actual almost basic need to be looked after in terms of, being welcome, being reassured. **And I think as a junior doctor, or any doctor, you should actually be aware of what their immediate needs are, and get into a relationship.** (Gavin, Focus Group 1, Site 3)

Some participants narrated being more active as recipients of poor communication practices by senior clinicians. For example, Suzanne narrated an event in which a senior doctor treated her like an object, with a junior doctor and medical student present. She talked about how she tried to redress the situation by speaking directly to the medical student:

There was no introduction to anybody. She just wafted into my room with two other gentlemen. She [senior doctor] just said to them both [junior doctor and medical student], '*Have any of you looked at this scar?*' And she just ripped the top of a sixteen-inch piece of plaster off. She said, '*Why has nobody examined this before?*' and she left it like that and walked out of the room. And I said to the year five student, I said, '*Can you just come back a minute? Please will you remember never to treat patients, or junior doctors, like that?*' It was appalling. (Suzanne, Focus Group 1, Site 3)

Participants talked about the need for junior doctors to understand how and when to involve carers in consultations, and to understand that issues such as confidentiality should be addressed with both the patient and the carer.

Specifically, carers narrated situations when they felt exasperated when information was denied. For example, using more metaphorical talk for exclusion, Kate (Focus Group 6, Site 1) narrated how she felt she came '*across a brick wall all the time*' in her encounters with receptionists, nurses and doctors. Appropriate carer involvement was associated with more positive narratives of care from carers and patients. In addition, patient representatives emphasised through their stories how it was essential for junior doctors to be prepared to give full and clear information, empowering patients to be involved in making decisions. Further, through their narratives participants emphasised the need for all healthcare professionals to tailor their approach appropriately to individual patient needs and capabilities. For example, Grace narrated a situation involving her sister who was assisted in using her inhaler by a healthcare professional following a junior doctor's assumption that she understood their instructions. Grace uses sarcasm as the person explaining clearly thought the task was simple and could not see that actually, for a patient with dementia, following those instructions was going to be very difficult:

My sister has Alzheimer's, I don't think she would have the concept of '*hold this thing* [Metre dosed inhaler], *put the thing at the end, press it in, inhale it*'. So she [healthcare professional, not junior doctor] said, '*Well, it's very simple*' [said sarcastically]. (Grace, Focus Group 4, Site 1)

Greater respect

Patient representatives shared several narratives illustrating a lack of respect towards vulnerable patients. The narratives portrayed unacceptable care, causing high levels of stress for patients and carers. Concerns regarding undignified care were expressed with regard to junior doctors, nurses and nursing home staff. One carer narrated a future hypothetical situation in which she described that she feared how hospital staff would treat her loved one more than the consequences of her illness, dementia:

Grace: ... It should not be like that. That I'm not fearing the illness [dementia] itself, that I'm afraid of how she's going to be treated.

Catherine: But she will have support.

Grace: Yes, and that's the big difference for me. I'm not frightened of the illness, I can deal with that. We as a family can deal with it, we're all very close. But **all of us are terrified of how she's going to be treated**. (Catherine and Grace, Focus Group 4, Site 1)

Participants narrated the importance of respect and for newly qualified doctors to be aware of this. They also spoke of the importance of senior doctors as role models for developing respectful attitudes, emphasising how critical their input is, especially within the first few months of junior doctors' careers. For example, Liz drew on her



experience of the healthcare setting as she narrated a generalised situation in which junior doctors begin to learn how to become doctors:

... when you become a junior doctor, you work within one firm, and really your role models are very limited. **And your attitudes will actually be formed by the attitudes of those senior doctors.** And I think during that year or first two years, housemen [junior doctors] really need the opportunity to discuss what they're learning, and what they're experiencing, with a wider group of people than the firm they're working for, so that they can actually stand back from what's going on and say, 'Well you know, that's not quite so good, you don't need to do it that way.' Because as I say, you're [junior doctor] the lost one. Because you're in the rough-and-tumble and everything's new. You form your attitudes very early on really. (Liz, Focus Group 2, Site 1)

Finally, participants described how a lack of consideration for individual patient needs could cause significant stress and emotional burden for patients and carers, as well as for junior doctors and other professionals involved in their care. This is illustrated by a carer's narrative, in which she describes an event when her husband broke the nose of a junior doctor who ignored her advice regarding the best way to approach her husband:

I can certainly share from a personal perspective, feeling a great deal of empathy for the junior doctor, who obviously didn't have a clue what they were doing, as didn't have any idea how to speak with my husband—did not say to me—this was in a hospital setting, in an acute setting, when I had obviously said—he was in the earlier stages of dementia looked a very fit healthy specimen, but I did kind of say I needed to be with him whilst he was examined—that was all fine, but I did kind of say, 'Can I just advise you how to do this?' The answer basically was 'no', so I sat back and thought, 'Now, wait for it.' So, it was the same speak as you would speak to any other adult, but **no chance to assimilate, to even test to see if there was any level of understanding.** But I looked at my husband's eyes and thought, 'There's a belt coming, I can see it.' He was smiling. So with that, he broke the nose of—bang—and I did say, 'Actually, I did try and point out about his dignity da-dee-da-da-da' because what he did, this guy, was go straight to my husband's stomach. (Rosie, Focus Group 6, Site 1)

To summarise this theme 'future doctors', participants talked about the key skills/qualities they wanted in their doctors specifically around patient-centred communication and respect. While they commonly narrated patient experiences (themselves or their loved ones) of feeling vulnerable, disempowered and disrespected in the healthcare setting, they instead wanted effective communication, respect, dignity, partnership working, clear information, empowerment and involvement, and they

expected that senior doctors should role-model those behaviours to their junior colleagues.

DISCUSSION

We asked patient representatives to share narratives of their experiences of junior doctors' preparedness for practice. Participants narrated a range of events involving junior doctors and the wider healthcare system, alongside sharing conversational narratives comprising hypothetical events based on past experiences, illustrating what they expect of tomorrow's doctors. Findings were similar across all patient groups, regardless of their conditions or educational backgrounds. Patients and carers' narratives primarily focused on problematic events rather than positive events, mainly concerning personal and interpersonal skills. This contrasts with existing preparedness for practice literature, which represents clinical perspectives and focuses mainly on knowledge and practical clinical skills.^{26 42} In comparison to stakeholders from our wider study, patient representatives were the only group to highlight the importance of including patients in their own care, which included helping them to understand their conditions and make decisions regarding treatment options, and acknowledging their important role.²⁶ Shared decision-making is known to positively influence health outcomes, and good interpersonal skills and information sharing enable patients' preferences to guide care.⁶⁰ Despite this, patients and relatives still expect guidance and involvement from doctors, especially in decisions such as end-of-life care.⁶¹

Patient representatives in our study recognised that medical training is generally of high quality, and proposed that junior doctors today are better prepared than previously. However, they expressed some concern, particularly regarding junior doctors' communication skills and abilities to provide individualised patient care. Instances relating to direct encounters with junior doctors were limited, and thus narratives often were in the form of more conversational narrative activities comprising stories of future or hypothetical events based on their prior experiences with healthcare professionals and students at all levels—including senior doctors—alongside secondhand narratives and stories from the popular press. Thus, through a range of narrative practices, participants highlighted the consequences of doctors' ignorance towards the needs of vulnerable patients, such as diagnostic overshadowing, which has been discussed in previous literature.^{29 62} According to our participants, the preparedness of medical graduates could be improved by their having: more experience in the community and across patient diversity, greater emphasis on personal skills and communication, more realistic experiences of the responsibilities that they will have as junior doctors and being exposed to senior clinical role models displaying appropriate professional attitudes and behaviours. As such, these aspects focus quite heavily on the issue of patient-centred professionalism.⁶³ Indeed,

current literature recognises the importance of patient involvement in medical students' development of their 'patient-centred professional identity'.⁶⁴ Furthermore, it may increase students' understanding of professionalism in terms of appropriate communication skills, listening and empathy, all of which feature strongly as aspects of patient-centred professionalism worldwide.^{65 66} Aligned with our participants' narratives, a number of researchers have highlighted the importance of role modelling as a key aspect for medical students' professional development, stressing that senior doctors' personal qualities will influence trainees' patient-centred professionalism development, as well as their clinical competence.^{67–70}

Our findings concur with current issues in healthcare provision and what is already known about the relationship between medical education and patient outcomes: life experience influences preparedness for practice¹; communication skills are a fundamental part of medical education⁷¹; understanding patients' backgrounds is important for patient–doctor relationships and health outcomes^{65 72}; professionals have a lot to learn from patients and their families⁴⁰; excluding patients and carers can negatively affect patient outcomes⁷³; and respect should be explicitly taught to medical trainees.⁷⁴ Changes in medical education prompted by the evolving needs of our society have also encouraged a greater emphasis to be placed on patient safety.³

Our findings also concur with other research that suggests public opinion of doctors can be influenced by what they see on the television.^{17 18} Indeed, we noticed that the popular press significantly influenced patient and public perspectives; in particular they appeared to find their way into the conversational narratives of our participants. Although to our knowledge there were no significant news stories regarding junior doctors being covered at the time of data collection, media coverage and governmental reports do appear to undermine patients' trust in doctors' abilities to care for vulnerable patient groups, as emphasised in the NHS Inquiry into Mid Staffordshire,¹⁹ and latterly reinforced in the recent *Shape of Training Review* in the UK.⁶³ Such reports appear to contribute towards feelings of anxiety among patients and the general public with regard to safe and effective healthcare delivery thereby feeding into societal *master narratives* (eg, 'the good doctor' narrative turns into a 'doctor death' one).⁷⁵ By contrast, longitudinal (and possibly voyeuristic) insights into the lives of junior doctors as they progress through the highs and lows of their training via television documentaries appear to provide a much needed humanistic antidote to media and governmental reports.

What was largely absent in our data was patient and carers' views of structural factors impacting on junior doctors' abilities to carry out their work. Although patients talked a lot about doctors' lack of time and the 'busy ward' conditions, for the most part individual or interactional factors were cited as being responsible for junior doctors' development (eg, poor role models, willingness to learn, self-awareness).

This contrasts starkly with the perspectives of others working in the healthcare environment, who also commonly point to issues such as staffing levels, ward culture and supervisors as facilitating or inhibiting factors to junior doctors' preparedness.²⁶

Our paper adds new weight to existing evidence on preparedness for practice, which has contributed to current medical education curricula. Patient representatives' actual experiences of junior doctors' preparedness for practice (rather than merely their views on this) have been explored for the first time. Importantly, these first-hand experiences and personal views of junior doctors were mainly positive, seeing them as being better prepared in 'human' factors than previous generations. Participants felt that doctors' personal attributes were very important, and that in some cases no amount of educational intervention would be able to change a person if they had the wrong attributes for being a doctor. Despite their positivity, however, participants also shared first-hand narratives of very poor communication from junior doctors and the negative consequences.

A key take-home message provided to us by patients and carers was that they narrated a separation between themselves and doctors and other healthcare professionals, for example: '*we're not all equal*' and '*on the other side of the fence*'. They narrated this as a barrier to doctors being able to understand patients, and thus meet their individual needs. It was not possible from our data to elicit the consequences that this might have had, but it does suggest that we have some way to go in terms of empowering patients to see themselves as equal partners in healthcare provision.

Strengths and challenges

There are several caveats to our study. Participants were mainly part of support groups and charities and thus might be more politicised than the general public.⁴¹ Almost a quarter of our participants were ex-healthcare professionals, which is likely to have affected their views as they drew on their own previous understandings and experiences as professionals within the NHS. As such, this subset of participants are likely to have narrated events quite differently compared with infrequent users of healthcare services due to their greater understanding of the healthcare workplace. Nevertheless, they provide insights that are informative in ways that only frequent users of the system could provide. They also spoke to us in the context of their current role as patients and/or carers, and it is possible that past experiences contributed to their willingness to participate in the study. The majority of participants were female, and due to our purposive sampling our groups poorly represented younger patients. Furthermore, participants narrated far more negative than positive events, despite being asked about what junior doctors appeared to be prepared for, that is, what were they doing that made patients feel comfortable and safe? However, we cannot conclude from this that patients consider junior doctors to be unprepared on the whole and/or they predominately have negative experiences of the healthcare profession. It



might be that patients expect and/or experience predominantly positive interactions with their doctors, but it is their negative experiences that they remember most of all due to these having a greater impact on them. Furthermore, in the focus group setting where participants are sharing their narratives, it might be that the negative 'shocking' stories are more 'newsworthy' and 'tellable'.⁴⁹ Finally, previous research has shown a strong link between negative events and memory, with negative events being more memorable than positive ones as they tend to involve more intense information processing to understand and deal with them.^{76 77}

Therefore, our findings need to be read with these issues in mind, and they are unlikely to be transferable to all UK patients, especially male and younger patients and their carers. For example, based on current research on health trends in younger patients, such a group might have discussed junior doctors' preparedness for issues such as mental healthcare, diabetes prevention, sexual/reproductive health, transitioning from child to adult care and the role of online media as a health information source for joint decision-making.^{78–80} Finally, although we draw the reader's attention to important features of language within the Results section, it was not feasible to explore fully here how participants narrated their experiences and the implications of the language used in this study.^{81 82} Metaphors were used extensively within our data and resonated with several categories previously identified by Rees *et al*,⁸¹ for example: hierarchy (eg, '*you're at the bottom of the heap*'); machinery (eg, '*I've fixed that hip*'); and war (eg, '*I'll fight my corner*'). Likewise, humour was also used (eg, '*Make sure they've got the right side for the heart, like*') as a method of building relationships and coping within focus groups.⁸²

Our findings also have strengths. Participants represent perspectives of patients and carers from three sites across the UK, with a range of backgrounds and experiences and so are likely to be reasonably representative of UK patients and carers with similar demographic profiles. Qualitative 'information power' was applied to guide the size of our sample.⁸³ Narrative interview methodology was used to collate participants' views, encouraging personal incidents to be shared where possible. Focus groups enabled the additional narration of conversational narratives that highlighted participants' orientation to the world of healthcare and of how junior doctors should be prepared for practice. Crystallisation of data between focus groups and individual interviews led to a broader and deeper understanding of the issues discussed,⁵³ with themes within the data being consistent irrespective of whether the data were collected using interview or focus group methods. Finally, the collaboration of numerous analysts from different professional backgrounds (clinical and social sciences) encouraged multiple ways of seeing the data, avoiding selectivity in our analysis.

Implications for educational practice and research

Despite our study limitations, our findings have a number of implications for educational practice and further research. In terms of educational practice, patient representatives had clear expectations of junior doctors and were passionate that their voices be heard and considered in the shaping of medical education. The data therefore highlight the necessity of patient involvement in medical education teaching: the views and experiences of patients and the public are important in creating junior doctors who will be adequately prepared to look after them. Indeed, participants provided us with clear messages about what they expect from junior doctors, often presenting a different picture to other 'clinical' participants from the wider study, such as clinicians, other healthcare professionals, educators and policymakers.²⁶

While patients and carers seemed confident that medical graduates had the necessary knowledge and practical clinical skills for effective and safe patient care, they demonstrated concerns about the extent to which junior doctors are prepared for the personal and interpersonal skills essential for promoting individualised patient care and shared decision-making. They emphasised the importance of communicating effectively with patients and carers, being attentive and respectful to individual needs, and the value of experiencing a wide variety of patients and environments.

As a result, we suggest three things for medical education: greater clarity and training is needed regarding the practicalities of sharing information with carers, there should be more opportunities for students to experience first-hand the impact of illness on patients and carers (eg, by attending patient support groups), and senior clinicians should be encouraged to consider their responsibilities as role models and the influence they have on the development of junior doctors' personal and interpersonal skills. In order for clinical practice to meet our public's rising expectations for healthcare delivery, greater involvement and empowerment of patients and carers is advocated.

Finally, in terms of further research, we think more detailed analyses of the needs and concerns of carers are needed, alongside further exploration of patients' first-hand experiences with junior doctors, and consideration of how patients and the public form their views on healthcare, including the influence of the media. Furthermore, future research with larger samples of patient representatives would benefit from an exploration of the differences in experiences and expectations by educational background of patient representatives and perhaps different disease states (eg, chronic illness, palliative care, acute illness). Finally, further linguistic analyses would yield a greater understanding of patients' perceptions of newly qualified doctors and how those perceptions were formed.

CONCLUSIONS

This study explores how well junior doctors (ie, medical graduates in their first 2 years after graduation) are prepared for clinical practice, according to patients, their representatives, and carers' personal experiences and expectations. We decided to collect their voices because the topic of graduates' preparedness for work has been mostly investigated in terms of medical knowledge and practical skills from the perspectives of junior doctors and their supervisors, with little concern about patients and carers' views and evaluative comments of medical training. Our findings support the view that patients and carers hold a set of clear expectations around junior doctors' roles and practices, and that patients' views are important for preparing junior doctors for practice. Our findings highlight the necessity for greater dialogue between patients, doctors and educators in order to bring forth greater clarity and alignment of expectations for patient care. This study adds evidence to existing research on preparedness for practice, which has contributed to the development of current medical educational curricula.

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REFERENCES

1. Bearman M, Lawson M, Jones A. Participation and progression: new medical graduates entering professional practice. *Adv Health Sci Educ Theory Pract* 2011;16:627–42.
2. Towle A, Godolphin W. A meeting of experts: the emerging roles of non-professionals in the education of health professionals. *Teaching in Higher Education* 2011;16:495–504.
3. Weiss KB, Bagian JP, Nasca TJ. The clinical learning environment: the foundation of graduate medical education. *JAMA* 2013;309:1687–8.
4. Berwick DM, Finkelstein JA. Preparing medical students for the continual improvement of health and health care: Abraham Flexner and the new "public interest". *Acad Med* 2010;85:S56–S65.
5. Hays RB. Reforming medical education in the United Kingdom: lessons for Australia and New Zealand. *Med J Aust* 2007;187:400–3.
6. Onishi H, Yoshida I. Rapid change in Japanese medical education. *Med Teach* 2004;26:403–8.
7. Pershing S, Fuchs VR. Restructuring medical education to meet current and future health care needs. *Acad Med* 2013;88:1798–801.
8. Segouin C, Jouquan J, Hodges B, et al. Country report: medical education in France. *Med Educ* 2007;41:295–301.
9. Phillips DP, Barker GE. A July spike in fatal medication errors: a possible effect of new medical residents. *J Gen Intern Med* 2010;25:774–9.
10. Vaughan L, McAlister G, Bell D. 'August is always a nightmare': results of the royal college of physicians of edinburgh and society of acute medicine august transition survey. *Clin Med* 2011;11:322–6.
11. Innes E. Black Wednesday: Today junior doctors will start work - and cause death A&E death rates to increase by SIX per cent. In *Mail online*. London, 2013. <http://www.dailymail.co.uk/health/article-2385931/Black-Wednesday-Today-junior-doctors-start-work-causing-A-E-death-rates-6.html> (accessed 4 Aug 2017).
12. Picard A. The Globe and Mail. Are July's increased hospital deaths really caused by rookie doctors? 2013 <https://www.theglobeandmail.com/life/health-and-fitness/health/are-julys-increased-hospital-deaths-really-caused-by-rookie-doctors/article12970588/> (accessed 4 Aug 2017).
13. Donnelly L. The Telegraph. Junior doctors urged to 'know their limits' on black wednesday. 2013 <http://www.telegraph.co.uk/news/health/news/10226292/Junior-doctors-urged-to-know-their-limits-on-Black-Wednesday.html> (accessed 4 Aug 2017).
14. General Medical Council. National training survey 2012: key findings. 2017 http://www.gmc-uk.org/National_training_survey_2012_key_findings_report.pdf_49280407.pdf (accessed 4 Aug 2017).
15. Levey RE. Sources of stress for residents and recommendations for programs to assist them. *Acad Med* 2001;76:142–50.
16. Archer J, Regan de Bere D, Bryce M, et al. Understanding the rise in fitness to practice complaints from members of the public: final report to the general medical council. 2014. 2017 http://www.gmc-uk.org/static/documents/content/Archer_et_al_FTP_Final_Report_30_01_2014.pdf (accessed 4 Aug 2017).
17. Chory-Assad RM, Tamborini R. Television exposure and the public's perceptions of physicians. *J Broadcast Electron Media* 2003;47:197–215.
18. Stinson ME, Heischmidt K. Patients' perceptions of physicians: a pilot study of the influence of prime-time fictional medical shows. *Health Mark Q* 2012;29:66–81.
19. Francis R. Report of the mid staffordshire nhs foundation trust public inquiry volume 2: analysis of evidence and lessons learned (part 2). 2013. 2017 <http://webarchive.nationalarchives.gov.uk/20150407084957/http://www.midstaffpublicinquiry.com/sites/default/files/report/Volume%202.pdf> (accessed 4 Aug 2017).
20. Greenslade R. The Guardian. Where the newspapers stand on the junior doctors' strike. 2013 <https://www.theguardian.com/media/greenslade/2016/apr/26/where-the-newspapers-stand-on-the-junior-doctors-strike> (accessed 4 Aug 2017).
21. Stone J. Independent. Junior doctors' strike: public increasingly blame both sides for all-out stoppage. UK, 2016. <http://www.independent.co.uk/news/uk/politics/the-public-increasingly-blame-the-government-for-the-junior-doctors-strike-a7003056.html> (accessed 4 Aug 2017).
22. Campbell D. The Guardian. Junior doctor nadia masood: 'hunt's driven a lot of us out of the NHS'. 2017 <https://www.theguardian.com/society/2017/jan/02/junior-doctor-nadia-masood-jeremy-hunt-driven-us-out-of-nhs> (accessed 4 Aug 2017).
23. Arena G, Kruger E, Holley D, et al. Western Australian dental graduates' perception of preparedness to practice: a five-year follow-up. *J Dent Educ* 2007;71:1217–22.
24. Kairuz T, Noble C, Shaw J. Preceptors, interns, and newly registered pharmacists' perceptions of New Zealand pharmacy graduates' preparedness to practice. *Am J Pharm Educ* 2010;74:108.

25. Kim S, Hwang WJ. Palliative care for those with heart failure: nurses' knowledge, attitude, and preparedness to practice. *Eur J Cardiovasc Nurs* 2014;13:124–33.
26. Monrouxe LV, Bullock A, Cole JA, *et al*. How prepared are UK medical graduates for practice? Final report from a programme of research commissioned by the general medical council. 2014 http://www.gmc-uk.org/How_Prepared_are_UK_Medical_Graduates_for_Practice_SUBMITTED_Revised_140614.pdf_58034815.pdf (accessed 4 Aug 2017).
27. Van Hamel C, Jenner LE. Prepared for practice? A national survey of UK foundation doctors and their supervisors. *Med Teach* 2015;37:181–8.
28. Goldacre MJ, Taylor K, Lambert TW. Views of junior doctors about whether their medical school prepared them well for work: questionnaire surveys. *BMC Med Educ* 2010;10:78.
29. General Medical Council. National training survey 2014. 2014 http://www.gmc-uk.org/NTS_bullying_and_undermining_report_2014_FINAL.pdf_58648010.pdf (accessed 4 Aug 2017).
30. Illing JC, Morrow GM, Rothwell nee Kergon CR, *et al*. Perceptions of UK medical graduates' preparedness for practice: a multi-centre qualitative study reflecting the importance of learning on the job. *BMC Med Educ* 2013;13:34.
31. General Medical Council. National training survey 2011. 2011 http://www.gmc-uk.org/NTS_trainee_survey_2011.pdf_45270429.pdf (accessed 4 Aug 2017).
32. Matheson C, Matheson D. How well prepared are medical students for their first year as doctors? The views of consultants and specialist registrars in two teaching hospitals. *Postgrad Med J* 2009;85:582–9.
33. Morrow G, Johnson N, Burford B, *et al*. Preparedness for practice: the perceptions of medical graduates and clinical teams. *Med Teach* 2012;34:123–35.
34. Tallentire VR, Smith SE, Skinner J, *et al*. Understanding the behaviour of newly qualified doctors in acute care contexts. *Med Educ* 2011;45:995–1005.
35. Dare A, Fancourt N, Robinson E, *et al*. Training the intern: the value of a pre-intern year in preparing students for practice. *Med Teach* 2009;31:345–350.
36. Imran N, Awais Aftab M, Haider II, *et al*. Educating tomorrow's doctors: a cross sectional survey of emotional intelligence and empathy in medical students of Lahore. *Pak J Med Sci* 2013;29:710–4.
37. Radhakrishnan P, Thorn P. Story telling: My most memorable patients - Lessons in humanism, reflection and the development of expertise. *J of General Inter Med* 2014;29:534.
38. Tait GR, Hodges BD. Residents learning from a narrative experience with dying patients: a qualitative study. *Adv Health Sci Educ Theory Pract* 2013;18:727–43.
39. General Medical Council. Patient and public involvement in undergraduate medical education: advice supplementary to tomorrow's doctors (2009). Edited by Council GM http://www.gmc-uk.org/Patient_and_public_involvement_in_undergraduate_medical_education_guidance_0815.pdf_56438926.pdf (accessed 4 Aug 2017).
40. General Medical Council. Patient and public involvement in undergraduate medical education, 2011. http://www.gmc-uk.org/Patient_and_public_involvement_in_undergraduate_medical_education_guidance_0815.pdf_56438926.pdf (accessed 4 Aug 2017).
41. Rees CE, Knight LV, Wilkinson CE. "User involvement is a sine qua non, almost, in medical education": learning with rather than just about health and social care service users. *Adv Health Sci Educ Theory Pract* 2007;12:359–90.
42. Monrouxe LV, Grundy L, Mann M, *et al*. How prepared are UK medical graduates for practice? A rapid review of the literature 2009–2014. *BMJ Open* 2017;7:e013656.
43. Cresswell K, Howe A, Steven A, *et al*. Patient safety in healthcare preregistration educational curricula: multiple case study-based investigations of eight medicine, nursing, pharmacy and physiotherapy university courses. *BMJ Qual Saf* 2013;22:843–54.
44. General Medical Council. Outcomes for graduates (tomorrow's doctors). 2015 http://www.gmc-uk.org/Outcomes_for_graduates_Jul_15_1216.pdf_61408029.pdf (accessed 4 Aug 2017).
45. Riessman C. *Narrative methods for the human sciences*. Thousand Oaks, CA: Sage Publications, 2008.
46. Lawler S. Narrative in Social Research. *Qualitative Research in Action*. edn. London: Sage, 2002. Edited by May T.
47. Labov W. Some further steps in narrative analysis. *J of Narrative Life History* 1997;7:395–415.
48. Ochs E, Capps L. *Living narrative*. Cambridge, MA: Harvard University Press, 2001.
49. Georgakopoulou A. Thinking big with small stories in narrative and identity analysis. *Narrative Inquiry* 2006;16:129–37.
50. Hymes D. *Ethnography, linguistics, narrative inequality. Toward an understanding of voice*. London: Taylor and Francis, 1996.
51. Sandelowski M. Telling stories: narrative approaches in qualitative research. *Image J Nurs Sch* 1991;23:161–6.
52. Vaughan S, Schumm JS, Sinagub J. *Focus group interviews in education and psychology*. California: Sage Publications, 1996.
53. Richardson L, EA SP. Writing: A method of inquiry. In *The sage handbook of qualitative research*. 3rd edn. Thousand Oaks, CA: Sage publications 2005. Edited by Denzin N, Lincoln Y.
54. Barbour RS. Making sense of focus groups. *Med Educ* 2005;39:742–50.
55. Lewis KL, Bohnert CA, Gammon WL, *et al*. The Association of Standardized Patient Educators (ASPE) Standards of Best Practice (SOBP). *Adv Simul* 2017;2:10.
56. Krueger R, Casey M. *Focus groups: practical guide for applied research*. 3rd edn. California: Sage, 2000.
57. Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG, eds. *Analysing Qualitative Data*. edn. London: Routledge, 1994.
58. Côté L, Turgeon J. Appraising qualitative research articles in medicine and medical education. *Med Teach* 2005;27:71–5.
59. Holt E, Clift R. *Reporting talk: reported speech in interaction*. Cambridge: Cambridge University Press, 2007.
60. Elwyn G, Edwards A, Kinnersley P, *et al*. Shared decision making and the concept of equipoise: the competences of involving patients in healthcare choices. *Br J Gen Pract* 2000;50:892–9.
61. Fosse A, Schaufel MA, Ruths S, *et al*. End-of-life expectations and experiences among nursing home patients and their relatives—a synthesis of qualitative studies. *Patient Educ Couns* 2014;97:3–9.
62. Jones S, Howard L, Thornicroft G. 'Diagnostic overshadowing': worse physical health care for people with mental illness. *Acta Psychiatr Scand* 2008;118:169–71.
63. Greenaway D. Shape of training: Securing the future of excellent patient care. 2013 http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf (accessed 4 Aug 2017).
64. Barr J, Bull R, Rooney K. Developing a patient focussed professional identity: an exploratory investigation of medical students' encounters with patient partnership in learning. *Adv Health Sci Educ Theory Pract* 2015;20:325–38.
65. Aelbrecht K, Rimondini M, Bensing J, *et al*. Quality of doctor-patient communication through the eyes of the patient: variation according to the patient's educational level. *Adv Health Sci Educ Theory Pract* 2015;20:873–84.
66. Hoffman KG, Griggs M, Donaldson JF, *et al*. Through patient eyes: Can third-year medical students deliver the care patients expect? *Med Teach* 2014;26:1–9.
67. Passi V, Johnson S, Peile E, *et al*. Doctor role modelling in medical education: BEME Guide No. 27. *Med Teach* 2013;35:1422–36.
68. Monrouxe LV, Rees CE. *Healthcare professionalism: improving practice through reflections on workplace dilemmas*. Wiley: Oxford, 2017.
69. Monrouxe LV, Rees CE, Dennis I, *et al*. Professionalism dilemmas, moral distress and the healthcare student: insights from two online UK-wide questionnaire studies. *BMJ Open* 2015;5.
70. Van Schalkwyk SC, Bezuidenhout J, De Villiers MR. Understanding rural clinical learning spaces: being and becoming a doctor. *Medical Teacher* 2014;5:1–6.
71. Kessler CS, Chan T, Loeb JM, *et al*. I'm clear, you're clear, we're all clear: improving consultation communication skills in undergraduate medical education. *Acad Med* 2013;88:753–8.
72. Canadian Federation of Medical Students. Diversity in Medicine in Canada: building a representative and responsive medical community. 2010 https://www.cfms.org/files/position-papers/diversity_in_medicine_-_updated_2010_cait_c_.pdf (accessed 4 Aug 2017).
73. Ha JF, Longnecker N. Doctor-patient communication: a review. *Ochsner J* 2010;10:38–43.
74. Spagnoletti CL, Arnold RM. R-E-S-P-E-C-T: even more difficult to teach than to define. *J Gen Intern Med* 2007;22:707–9.
75. Bamford R. Strawberry Media. Harold shipman: doctor death. 2002.
76. Habermas T, Meier M, Mukhtar B. Are specific emotions narrated differently? *Emotion* 2009;9:751–62.
77. Rees CE, Monrouxe LV, McDonald LA. Narrative, emotion and action: analysing 'most memorable' professionalism dilemmas. *Med Educ* 2013;47:80–96.
78. Diaz-Valencia PA, Bougnères P, Valleron AJ. Global epidemiology of type 1 diabetes in young adults and adults: a systematic review. *BMC Public Health* 2015;15:255.



79. Olfson M, Blanco C, Wang S, *et al.* National trends in the mental health care of children, adolescents, and adults by office-based physicians. *JAMA Psychiatry* 2014;71:81–90.
80. van Staa A, Sattoe JN. Young adults' experiences and satisfaction with the transfer of care. *J Adolesc Health* 2014;55:796–803.
81. Rees CE, Knight LV, Wilkinson CE. Doctors being up there and we being down here: a metaphorical analysis of talk about student/doctor-patient relationships. *Soc Sci Med* 2007;65:725–37.
82. Wilkinson CE, Rees CE, Knight LV. "From the heart of my bottom": negotiating humor in focus group discussions. *Qual Health Res* 2007;17:411–22.
83. Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies: guided by information power. *Qual Health Res* 2015;26:1753–60.

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